ADA Disease Management
SUCCESS STORIES

HOPE ▼ OPPORTUNITY ▼ COMMUNITY INCLUSION

SOUTHEAST MISSOURI

One gentleman was difficult for me to locate. I ended up with three different phone numbers for this client in CIMOR, CyberAccess, and from his pharmacy. None of these phone numbers worked and were disconnected. I then went to his last known address to find out that client no longer lived there. I was able to get his new address from the property manager but was informed that the apartment number was not known. I went to this address, not knowing which apartment to knock on, but I found the right one. This client informed me that he recently got his Medicaid taken, was unsure why this happened, and that he was out of medications. I assisted client to DFS office to advocate for client and within the week client got his Medicaid back. I also assisted client in getting his medications switched over to a local pharmacy since he was still using the pharmacy in the town where he lived before. I am currently assisting him in finding a primary care provider in the area.

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We have one young man who reports that he has been looking for a place to fit in and interact with a positive group of individuals he can share his own struggles with. He stated on Friday that getting admitted into our program this week is exactly what he needs. He stated that he wasn't aware that he could be in a substance use program since he isn't actively using. He was very grateful that we made contact with him and have set up the admission process. We are looking forward to helping him get on track. He is also interested in speaking to groups in the community about his journey. Our care coordinator will be working with him to fulfill this goal.

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Another man I am helping broke his back and is currently fighting for SSI. Client's wife is also ill and cannot work and is fighting for SSI. Family has very limited income and currently lives in an area they don't feel comfortable. I am assisting them in looking up housing options and linking them to resources such as clothing, Medicaid Transit, and SAFELINK phone. Client has expressed to me that he is very grateful that I contacted him and am helping his family.

WESTERN MO

DS began his Disease Management program at the Truman Medical Center after relapsing on alcohol and he being hospitalized due to his severe liver conditions. He met the Heartland Center/Truman Medical Center (TMC) Community Support Specialist in the hospital and she referred him to the CSTAR program. On March 18, he completed his intake and began substance abuse treatment. I met with DS on said date, he stated that he was still very ill and needed his medication filled immediately. He was taken by this writer to the pharmacy and all of his prescriptions were filled. DS felt much better after taking the medication that eliminated the toxins in his system. He lived at his sister's residence until receiving his April disability check and was able to move into an Independence, MO Oxford House. DS has transferred to the Independence MO CSTAR program and is maintaining his sobriety at this time. His goals for the future are to obtain his own housing, and we are working on the Shelter Plus paperwork at this time. DS has started his recovery process and his health has improved greatly since he began the Disease Management project. In addition, his wife (who also has an alcohol problem) is working on her issues in a recovery program.

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KF contacted Heartland Center after receiving a Disease Management letter informing that he is in our cohort and is eligible to receive services. He indicated that he had just been released from prison and was having difficulty adjusting to society. On March 19, I met with KF and he indicated that he needed his medication from TMC. A call was made to the pharmacy and he did have prescriptions on file. KF was transported to the pharmacy and his medications were obtained at that time. We transported him to TMC BH, due to his schizophrenia diagnosis. He was able to meet with a Qualified Mental Health Professional and a Psychiatric Nurse Practitioner

on the same day. He was able to obtain his psychiatric medication which has assisted him in staying focused. KF's main goal for the future is to obtain stable housing. He is currently living with a friend, but does not have his own room. We are filling out his Shelter Plus paperwork and also have an application for Save Inc., housing. KF has agreed to enter the CSTAR program for additional support and relapse prevention.

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Our outreach case manager visited BW about a month ago at her home for the first time. On the first visit, it was evident she was very confused about her numerous medications which she is taking for multiple physical and mental health conditions (diabetes, chronic back and neck pain, migraines, PTSD, depression). Her medications were disorganized; she was not taking them as prescribed, and was out of some of them. BW had been getting all of her medicines from a physician 45 miles away who would no longer see her. Our Health Care Home nurse visited the next day and provided education about her meds and assisted in organizing them and making an appointment with a new primary care doctor. The case manager accompanied consumer to the first appointment with the new primary care physician and reviewed her medical needs and medications with the new doctor. BW is usually confused and has a poor short term memory. Her case manager assisted in transferring all of her medications to the Genoa pharmacy at the mental health center and they filled them in an organizer pill (bubble) pack to increase compliance. Her case manager reviews her medications with her on a weekly basis and is hopeful her level of confusion will decrease.

On the first visit it was also observed that she was sleeping on an old worn out sofa. She has chronic pain in her back and neck and the old sofa was making it worse. She reported she could not afford a bed. Her case manager assisted in obtaining a new bed, sofa, and other needed household items from a local charity organization. Client's teeth are in very poor condition with gum disease, missing teeth, and teeth that are broken. Her case manager assisted in completing the application to qualify her for the 100 percent discount at Truman Medical. She will be getting her teeth pulled soon and then will work with her case manager to obtain dentures at a discounted rate. It is obvious from her teeth (and the medical record) that she abused meth for many years. Her case manager also provided the information about where to obtain a free cell phone for disabled persons and made the appointment and accompanied her. We feel very hopeful, with the continued coordination of BW's healthcare, her mental and physical status will continue to improve!

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CC has biliary cirrhosis among other serious health conditions (diabetes, hypertension, asthma, major depressive disorder). He has been advised to lose 60 pounds so he can be placed on the liver transplant list. His medication is vital and he has a large spendown for Medicaid. His case manager assisted him in transferring his medication to the Genoa pharmacy at the mental health center. His meds are now in a bubble pill pack. This increases his chances of taking them as prescribed and provides support to his mother, his caregiver, who is blind and elderly. Consumer's mother explained that without his medication it can be a life and death situation. The liver medicine, which is very expensive, is vital. When the client does not have it, his mental and physical status completely changes. The last time this occurred, the consumer attacked his mother. CC also has asthma/ breathing problems and is on oxygen. The case manager and Health Home nurse have provided diabetic education and resources for healthier eating. The case manager has made a referral to the YMCA and will assist the client in starting an exercise routine. Consumer's mother reports that without these supports (medication, exercise, and oxygen) CC's life expectancy would be about a year. We are hoping we can assist in extending his life far beyond that!

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On the first visit with "JH," he reported he was going to his lose his Social Security Disability Income (SSDI) if he didn't get the paperwork back to them by the next day. He had failed to report his new address and when he received the forwarded paperwork from SSI, didn't know what to do. He couldn't get to the Social Security office and was just holding on to the paperwork. The outreach case manager accompanied JH to the Social Security office the next day and advocated for the client, explaining his situation. They extended the deadline and, as a result, he did not lose any of his income. Also on the first visit, JH explained he and his family were very worried because they had received a shut off notice on the electricity due to non-payment. Shut off was scheduled for the next week. DMH DM housing funds were utilized to pay this bill

and avoid shut off. His case manager has arranged for his daughter, who is his caregiver, to be paid by a home health company to provide care services.

CENTRAL MISSOURI

After tracking down an updated address I drove out to the home of an individual in the cohort. There was an angry diatribe taped to the door forbidding the landlord to enter the premises while eviction proceedings were going on. Unsurprised when there was no answer at the door in spite of the television blaring, I left a note offering Community Support assistance. Later that day I received a call and scheduled an appointment to come back out.

This individual was intoxicated and desperate. His live-together partner had OD'd a month ago and his drinking, always problematic, had become extreme. He was at the end of his rope and thinking desperate thoughts. We crafted a plan to provide some Community Support to facilitate the moving and storage of his possessions, some medical follow up, and then a trip to the hospital for medical detoxification. After the usual "no shows" and delays expected with working with someone in active addiction, a patient, supportive, and nonjudgmental approach saw this individual into medical detoxification and subsequent enrollment in CSTAR with residential support. We will continue to support and encourage him whatever choices he makes regarding substances, but for right now, at least we have a gentleman who is four days sober.

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Another individual presented for treatment while I was following up leads on old addresses. He was enrolled in CSTAR and has come to outpatient treatment almost every day. He has had a couple of slips but has a strong relationship with his counselor and feels a part of the Phoenix Community. Our welcoming and encouraging environment, embodied in our Modified Therapeutic Community approach, has kept him engaged even when his decision-making has been self-defeating. As he continues to struggle, we have referred him to our psychiatrist and he is awaiting lab results to begin Naltrexone for the assistance he needs to be successful in his life and death struggle with alcohol.

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This individual is struggling with sickle cell anemia and had a lot of hospitalizations over the winter. He is new in our community and does not have a lot of social connection and was unfamiliar with the resources available. He did not self-identify as having a substance use problem, but reported he was using marijuana to help manage his chronic pain. He agreed to services and was assessed and enrolled in CSTAR. After his initial counseling session, he reduced his marijuana use but had to increase his prescribed opiate medications leading to increased side effects and a lessened quality of life. When we wrote a treatment plan together, we agreed to discuss this quandary with his doctor to see if we can find a way to manage his pain, maintain a good quality of life, and also allow him to be able to pass a pre-employment drug screen. Recognizing that sickle cell is the issue we need to manage has been a growth experience for his substance use counselor. Identifying a last period of baseline stability was key; this individual has now restarted physical therapy and a doctor-approved exercise plan, which he was doing when he had better symptom control. We have also identified a desire to give back to the community and assisting in forming a local sickle cell support group is part of this individual's treatment agenda. While we do not have all the answers to his complex medical conditions, knowing when it has been better in the past and empowering this individual to take some action has proven invaluable.

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EASTERN MISSOURI

JB is truly a success story. JB had been stricken by cancer and hospitalized in November of 2012 – January of 2013. JB was receiving chemo treatments in February and March 2013; as of April 2013 Derrick was informed he was in remission. JB used heroin for more than ten years. When the knock came on his door in March 2014 from a DM Outreach CSS, following a brief introduction, JB stated, "I need some services." JB called the DM Outreach CSS back that evening and asked, "how did you know I was using?" The CSS replied, "When I shared with you the services that we could provide for you, your eyes told the story." JB has been actively engaged in CSTAR, attending and participating regularly in an array of services. He is utilizing

medications to support his recovery and, as of today, is on track to receive his first Vivitrol injection next week!

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When our DM Outreach CSS located KM, he was living alone with no phone following double bypass heart surgery. KM was isolated and not following through with medical appointments, as well as unable to contact family members or other supports. James was initially very mistrusting when our CSS shared with him that he could assist him in getting a free cell phone. Our CSS helped KM complete the application for a SafeLink phone and when KM received the phone he said, "I really didn't think that you would be back." Our CSS continues to build rapport with KM and is working with him so he can learn how to budget his monthly phone minutes so he can continue to benefit from having a phone. Hopefully, KM will be ready for CSTAR admission soon!

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DK met with our DM Outreach CSS throughout the month of March and was admitted into CSTAR in April 2014. When our CSS first met DK and was invited into her home, she could not believe her eyes. DK was living in deplorable conditions with dilapidated surroundings, little food, little furniture, and exposed wiring. DK made it clear that she did not want to move. Our CSS continued to visit DK, sometimes sitting on crates outside of her house. Through continued rapport-building, our CSS discovered that DK has family not too far away. As the relationship continues to grow, DK is willing to entertain alternate housing options that would put her closer to her family. While DK hasn't moved yet, she has been admitted into CSTAR and willing to discuss options. Our CSS is assisting with teaching her how to apply life skills in her current home environment to improve living conditions as much as possible until DK decides that she is ready to move.

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We have a gentleman who was admitted in mid-June with severe alcoholism (self-admitted), Hepatitis B, Ascites w/catheter in abdominal cavity to treat, bleeding **esophageal varices** and cirrhosis of the liver. He was bleeding on a daily basis from his paracentesis and unable to stop drinking. He wanted to come to outpatient groups so we tried this for a few days but he really wasn't appropriate with continued drinking that exacerbated the bleeding which was an infectious exposure issue. **Rather than discharge, our CSS continued to see him in his home** and at one point he said that he wanted to quit drinking and was willing to go to detox (and definitely needed medical detox), but when he got to detox with our CSS he told the hospital employees that he did not drink alcohol so they would not admit him.

Again, instead of saying that he wasn't willing to comply with treatment and discharging him, our CSS continued to visit him in his home and talk about options as well as discuss what might happen if he continued to drink when his doctor has told him that he needs to get himself in good enough shape to even be eligible for a liver transplant. Without a liver transplant, he has been told that he will not live longer than a year.

Early last week this gentleman expressed to his CSS that he wanted to stop drinking and that he would go to detox if she would help get him there; she got him to detox! Our CSS checked on him a couple of times when he was in the hospital and he completed medical detox several days later. As you can imagine, he has no social supports in place so he called our CSS on her work cell. It happened to be her day off but she went above and beyond and assisted him in getting his medications and back to his home.

He has come to treatment for a couple of days as his health conditions have already improved enough that the infectious control risks have been minimized and he is eager to learn from others and for social interaction. He is scheduled for a MAT appointment tomorrow with hopes that he can tolerate oral naltrexone at a low dose that will help him with alcohol cravings as he wants to work on health & wellness to gain eligibility for a liver transplant. This gentleman is only 48 years old.

Am keeping my fingers crossed on the MAT as it could really give him the edge that he needs but we will figure something out if he is ineligible. Stories like this make me so proud of my staff as they truly see the potential and value of one human being who might not have been looking for help and who had given up on himself and was willing to drink himself to death less than 10 days ago but is sober for today because someone hung in there with him and kept showing up on his door step for a few weeks!

SOUTHWEST MISSOURI

I had been searching for one of our listed cohorts for a couple of months to no avail. I sent a letter, but it was returned with "invalid address". I reviewed Mug Shots and was able to obtain a picture of him so I knew his physical appearance.

On the way into work one "random" day, at the intersection of Chestnut and Highway 65, I observed a man holding a sign asking for money…when I pulled closer I recognized him as the man in the Mug Shot picture. When my vehicle approached him, I verified his first name and instead of money…I handed him my card and encouraged him to call me. *Due to time constraints of my daily agenda I was not able to pull over and meet with him right then, so I was very hopeful that he would contact me.*

After arriving in my office that day I received a call from the gentleman. I was able to introduce myself and explain the services I can offer. He expressed some immediate needs and I was able to start assisting him toward meeting his needs!

What I learned:

Always be on the look out and BE PREPARED:

I was not anticipating running into this individual at that moment…had I not been paying attention and had my contact information readily available…I would have missed an opportunity!

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